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# RESULTS OF EMERGENCY TREATMENT TAPES USED IN BACK SURGERY

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I have recently reviewed the hospital records of Dr. Art Gladman. As you know, I administered his anesthetic for his second back surgery. When I made my pre-operative visit to him the evening before, he was using the Hemi-Sync tapes, and consequently we had a long discussion about them. I enthusiastically agreed to use them for him in the operating and recovery rooms. He told me that with his first back surgery, he had been very groggy and disoriented for several days. He also had to have a bladder catheterization for urinary retention. His recollection of the entire perioperative period was most unpleasant.

Because he wanted to use as little medication as possible, and because he seemed quite relaxed about the upcoming surgery (especially after our discussion), we agreed that I would not order any premedication for him. He arrived in the "holding area" calm and listening to his tape. I started his intravenous, and gave him a small amount of Valium (5 mg.) and Fentanyl (a short acting narcotic, 1 cc.) intravenously. He then came to the operating room where he was anesthetized and the surgery was uneventful. He required less than the usual amount of anesthesia, and lost minimal blood. He was then taken to the recovery room, and awakened immediately. He used the recovery tape, and required no pain medication. He was soon returned to his room. He required no post-operative pain medication during the remaining hospitalization, and was discharged on the fourth post-operative day.

By contrast, following his first back operation, he was medicated two times in the recovery room with 20 mgs. of Demerol (this is not really very much). However, after he returned to his room, he required more narcotic, and continued to need this for the next four days. The amounts of Demerol required on a daily basis were as follows: 75 mgs., 350 mgs., 150 mgs., 50 mgs., and 100 mgs. In addition, he received other milder pain medications. He had significant blood loss in surgery, and developed a post-operative hematoma (bleeding into the tissues) accompanied by a fever of several days' duration. He was not discharged until the ninth post-operative day.

Unfortunately, one patient does not constitute a "controlled study." Also, it is not necessarily valid to compare the two experiences, as there may well have been other variables. However, the patient and surgeon were the same, the operations were similar and for the same problem, and the basic anesthetic techniques and agents were the same. The first operation took thirty minutes longer—which may or may not be of significance. Furthermore, even on a non-comparative basis, Art's entire perioperative course the second time was exemplary.

I was sufficiently impressed that I have begun using the tapes for the majority of my patients whenever feasible. My feeling is that the tapes are of significant help in many, if not most cases. I am currently in the process of setting up a protocol for a “controlled study” in my department, with the help of my colleagues. I hope to have some clear results in a few months.